STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012722	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR OF MID-NORTH INDIANA	25 EXECUTIVE DRIVE SUITE C LAFAYETTE, IN 47905

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N 000	Initial Comments This was an initial home health state licensure survey. Survey dates: October 4, 9, and 10, 2012 Facility: #012722 Medicaid Vendor: N/A Surveyors: Bridget Boston, RN, PHNS Census: 7 Skilled: 3 Aide only: 2 Homemaker only: 2 Home Visits: 2 Quality Review: Joyce Elder, MSN, BSN, RN October 17, 2012 This survey was altered as the result of an IDR 12/12/12. je	N 000		
N 470	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This RULE is not met as evidenced by: Based on observation, interview, and agency policy review, the agency failed to ensure failed to ensure the agency's infection control policies were complete and it had provided services in accordance with standard infection control	N 470		

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N 470	Continued From page 1 policies and procedures in 1 (patient 5) of 2 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's current patients. The findings include: 1. The agency's policy for Infection Control indicated it was no longer in effect and contained a red line draw across and stated, "Updated 1/13/12." 2. On 10/10/12 at 5:30 PM, employee E indicated she was unable to find the updated infection control policy. She indicated the agency no longer is following the CDC guidelines and will be following the WHO guidelines and provided one policy titled "January 12, 2012 Update to Hand Hygiene." 3. The policy titled "January 12, 2012 Update to Hand Hygiene" stated, "To prevent the spread of infection, your healthcare worker / caregiver should use hand hygiene at the following key moments: ... Before touching blood or bodily fluids, ... after touching your surroundings." The policy does not contain a procedure for hand hygiene and the approved products to be used by the staff for the completion of hand hygiene, the precautions to take to prevent the spread of communicable disease during routine care, did not address or define routine standard infection control precautions to follow in the home and the specific precautions to follow when the facility was providing care with known infectious disease causing organisms. 4. On 10/9/10 at 1 PM during a home visit with employee E and U, employee U was preparing to	N 470		

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N 470	Continued From page 2 transfer the patient via Hoyer lift. Employee E walked to the patient and picked up the patient's urinary drainage bag from the side of the patient's chair and placed on the patient's lap without completing hand hygiene. No gloves were worn when she touched and moved the drainage bag. As the patient propelled the wheelchair to another room, employee E picked up items and moved them along the patient's path. She had not completed hand hygiene before touching these items in the home from the initial contamination with the drainage bag. After the patient was placed into the bed by employee U, employee E walked up to the bed and, without hand hygiene from previous contamination, placed her hand on the trapeze over the patient's bed and encouraged the patient to use it for assistance with bed mobility. Then, without gloves or hand hygiene, employee E picked up the urinary drainage bag from the top of the bed and placed on the side of the bed. She continued to touch and move the tubing several times, then she completed hand hygiene.	N 470		
N 494	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.	N 494		

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N 494	Continued From page 3 This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all patients / patient representatives were informed of their rights prior to the beginning of care for 1 of 3 (# 1) skilled patient records reviewed with admission date after 2/17/12 (previous survey) with the potential to affect all the agency's patients. Findings include: 1. Clinical record #1, a pediatric patient with start of care 8/10/12, failed to evidence the patient's representative received the patient rights. 2. On 10/10/12 at 3:35 PM, employee E indicated she was not able to find evidence patient #1 received their patient rights. 3. On 10/10/12 at 3:35 PM, employee N indicated she reviewed the back up file of scanned documents and was not able to find evidence the patient's representative received the patient rights document.	N 494		
N 506	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.	N 506		

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N 506	Continued From page 4 This RULE is not met as evidenced by: Based on interview and review of administrative documents and clinical records, the agency failed to evidence the patients admitted after 2/17/12 (last survey) and in receipt of the agency patient rights document, failed to evidence the patients were advised of their right to be given a reasonable discharge notice from the agency in 4 of 4 records reviewed (# 2, 3, 5, and 6). Findings include: 1. The agency admission packet contained the undated document titled "Patient Rights and Responsibilities." The admission packet and "Patient Rights and Responsibilities" document failed to evidence the patient right of a reasonable discharge notice from the agency. 2. Clinical record # 2, start of care (SOC) 9/6/12 failed to evidence the patient was informed of the right to a reasonable discharge notice from the agency as part of the patient right document. 3. Clinical record # 3 SOC 3/26/12 failed to evidence the patient was informed of the right to a reasonable discharge notice from the agency as part of the patient right document. 4. Clinical record # 5 SOC 7/25/12 failed to evidence the patient was informed of the right to a reasonable discharge notice from the agency as part of the patient right document. 5. Clinical record # 6, SOC 10/1/12 failed to evidence the patient was informed of the right to a reasonable discharge notice from the agency as part of the patient right document. 6. On 10/10/12 at 4:30 PM, employee E indicated	N 506		

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N 506	Continued From page 5 the rights document did have this particular right and indicated the statement listed at #10 on the rights document and stated, "Be informed that you may participate in the development of your plan of care treatment, the periodic review and update, discharge plans" was to cover this patient right.	N 506		
N 522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure home health aide visits were provided as ordered on the physician directed plan of care and treatments were provided only as ordered in 3 of 6 active records reviewed (# 2, 4, and 6) with the potential to affect all the patients of the agency. Findings include: 1. Clinical record #2 included a physician ordered plan of care dated 9/6/12 through 11/4/12 and orders for home health aide 2 to 3 times a week for up to 2 hours per visit. A. The record failed to evidence a physician order for an evaluation for home health services prior to the agency completing the comprehensive assessment B. The record failed to evidence the agency provided any aide services during week one of the certification period.	N 522		

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N 522	Continued From page 6 C. The record failed to evidence a minimum of 2 aide visits were provided each week as ordered on the plan of care. D. On 10/10/12 at 3:45 PM, employee E indicated there was not additional documentation nor an order to decrease the aide visits as ordered on the physician directed plan of care. 2. Clinical record # 6, start of care 10/1/12, included a plan of care with orders for home health aide 5 days a week from 10:30 AM to 3 PM and to assist the patient with medication reminders and homemaking tasks. The clinical record failed to evidence any services were provided until 10/8/12. On 10/9/12 at 10:36 AM, employee E indicated there was no additional documentation nor a physician order to discontinue the aide services as ordered for week one on the plan of care (10/1/12 through 10/7/12). 3. The policy titled "Section 02.09 -Admission Assessment Visit" dated 7/6/12 stated, "When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care."	N 522		
N 524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:	N 524		

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N 524	Continued From page 7 (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on clinical record review, observation, interview, and policy review, the agency failed to ensure an individualized plan of care was developed and included all the required elements in 5 of 6 clinical records (2, 3, 4, 5, and 6) reviewed with the potential to affect all the patients of the agency. Findings include: 1. Clinical record # 2 included a plan of care dated 9/6/12 through 11/4/12 with the admission diagnoses CVA, hypertension, and atria fibrillation that states, "Safety Measures ... Fall Precautions, Bleeding Precautions." The plan of care failed to evidence interventions and patient specific measurable goals for the identified patient needs. 2. Clinical record # 3 included a comprehensive assessment dated 3/26/12 which determined the patient was at risk for falls. The record included	N 524		

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N 524	Continued From page 8 plans of care dated 3/26/12 through 5/24/12, 5/24/12 through 7/22/12, and 9/12/12 through 11/10/12 with the admission diagnosis hypothyroidism that stated, "Safety Measures ... Fall." The plan of care failed to evidence interventions and patient specific measurable goals for the identified patient needs. 3. Clinical record #4 included a plan of care for the time period 7/31/12 through 9/28/12 with the diagnoses congestive heart failure, atrial fibrillation, and diabetes mellitus that stated, "Safety Measures: Oxygen, Bleeding, diabetic, and fall precautions." The plan of care failed to evidence interventions and patient specific measurable goals for the identified patient needs. 4. Clinical record # 5 included a comprehensive assessment dated 7/25/12 that indicated the patient had paraplegia, decubitus ulcer coccyx and right hip, ambulatory device - wheelchair, and bed and wheelchair bound. The record included a plan of care for the time period 7/25/12 through 9/22/12 that stated, "Safety Measures - fall precautions." The plan of care failed to evidence the interventions and specific patient measurable goals to meet the identified patient needs. A. On 10/9/12 at 1 PM, during an home visit observation with employees E and U, the patient was observed transferred via Hoyer lift from a wheelchair to a hospital bed with two full side rails. The patient was instructed to reach a trapeze which was above the head of the bed to assist with bed mobility. The patient had a Foley catheter and drainage bag, a low air loss mattress on the bed labeled "ScanAmericia," and heel protectors. Employee U was observed to place a glass of soda in a glass with a straw at bedside and within reach of the patient before	N 524		

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N 524	Continued From page 9 leaving the patient home alone reclined in bed. B. The record evidenced a 60 day summary dated 9/25/12 and written by employee E that stated, "Client now has some difficulty with swallowing solid foods and chokes intermittently. Denies difficulty with fluids. Safety measures updated to include swallowing precautions." C. The plan of care dated 9/23/12 through 11/21/12 failed to evidence the Hoyer, trapeze, Foley catheter, a low air loss mattress, and heel protectors. The plan of care stated, "Safety Measures - fall precautions, ... swallowing precautions." The plan of care failed to evidence the specific patient interventions and measurable goals to meet the identified patient needs. 5. Clinical record # 6 included a plan of care dated 10/1/12 through 11/19/12 that identified the admission diagnoses were aftercare of a myocardial infarction and seizure disorder. The plan of care stated, "Safety Measures - Seizure precautions and fall precautions." The plan of care failed to evidence the specific durable medical equipment utilized by the caregivers to provide the patients care and specific interventions and measurable goals to meet the patient's identified needs. 6. The undated policy titled "Section 02.14 - Medical Plan of Care, Physician Orders, and Medical Supervision" states, "Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, chiropractor, optometrist or podiatrist. Be developed in consultation with the agency staff. Include all services to be provided if a skilled service is being provided. Cover all pertinent diagnosis. Include the following: Mental status,	N 524		

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N 524	Continued From page 10 Type of services and equipment required, frequency and duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, therapy modalities specifying length of treatment, any other appropriate items. ... All medications, treatments and services provided to patients must be ordered by a physician. ... The medical plan of care will be used as the care plan and will include reasonable, measurable, and realistic goals as determined by the patient assessment. The care plan will also addresses rehabilitation potential and discharge plans."	N 524		
N 547	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse obtained physician orders for the evaluation of the patient for home health services in 4 of 6 clinical records reviewed (# 2, 4, 5, and 6) with the potential to affect all patients of the agency. Findings include: 1. Clinical record # 2 included patient consent for treatment and admission to home health care and	N 547		

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N 547	Continued From page 11 a plan of care dated 9/6/12 through 11/9/12. The record failed to evidence documentation of a physician order for evaluation and home health services. The record evidenced the patient received services from employee Q on 9/6/12, employee E on 9/10/12 and 9/27/12, employee employee R on 9/13/12 and 9/20/12, and employee T on 9/24/12. 2. Clinical record # 5 included patient consent for treatment and admission to home health care and a plan of care dated 7/25/12 through 9/22/12. The record failed to evidence documentation of a physician order for evaluation and home health services. The record evidenced the patient received services from employee E on 7/25/12, 8/24/12, and 9/16/12; employee R on 7/30/12, 7/31/12, 8/6/12, 8/7/12, 8/14/12, 8/21/12, 8/27/12, 8/28/12, 8/31/12, 9/4/12, and 9/11/12; and employee T on 8/1/12, 8/8/12, 8/10/12, 8/13/12, 8/15/12, 8/17/12, 8/20/12, 8/22/12, 8/29/12, 9/7/12, 9/10/12, 9/12/12, and 9/12/12, and 9/14/12. 3. Clinical record 6 included a comprehensive assessment dated 10/1/12 completed by employee Q. The clinical record failed to evidence documentation of a physician order for an evaluation and home health services. On 10/4/12 at 4:45 PM, employee E indicated the patient was admitted to care and was scheduled for care on 10/8/12. 4. The policy titled "Section 02.09 Admission Assessment Visit" states, "When skilled care is to be rendered during the admission visit, physician orders will be obtained prior to the performance of care."	N 547		

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N 547	Continued From page 12 5. On 10/4/12 at 4:45 PM, employee E indicated the agency does not obtain orders from a physician for the evaluation and admission to home health. and developing a medical plan of care for the patient.	N 547		